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Explaining Perceptions and Experiences of Midwives and General Practitioners of the Barriers Facing their Sexual Conversations with Postmenopausal Women: A Study of the Mediating Role of Subjective Norms

Talat Khadivzadeh [1], Robab Latifnejad Roudsari [1], *Masumeh Ghazanfarpour [2]

[1]Nursing and Midwifery Care Research Center, Mashhad University of Medical Sciences, Mashhad, Iran.
[2]Student Research Committee, Kerman University of Medical Sciences, Kerman, Iran.

Abstract

Background: The number of domestic studies to identify subjective norms for improving the quality of sexual education programs is limited. The aim of the present study is to explain the perceptions and experiences of midwives and general practitioners of subjective norms affecting the sexual conversation with postmenopausal women.

Materials and Methods: This is a qualitative study. A combination of Graneheim & Lundman and Hsieh & Shannon methods was used for data analysis. A total of 14 midwives and 13 general practitioners were selected by purposive sampling. Data collection was performed using in-depth semi-structured individual and face-to-face interviews. The data were analyzed using MAXQDA (version 10).

Results: At first, 183 initial codes were extracted from the 27 interviews with midwives and general practitioners. The similar codes were then merged and finally, 25 codes were emerged in three categories and eight subcategories during the inductive process. Data related to subjective norms were placed in three main categories: "expectation of understanding religious and cultural sensitivities (by family and society)", "expectation of providing services based on respect for privacy and the principle of confidentiality", and "expectation of scientific and professional performance".

Conclusion: Midwives and general practitioners did not hold sexual conversations under the influence of various legal or natural persons in the society such as menopausal clients themselves, patients' spouses, professional/organizational rules and regulations, university security officers, colleagues, family, judicial authorities, and superiors.

Key Words: Barriers, Conversation, Midwives, Sexual, Subjective norms.

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Corresponding Author:

Masumeh Ghazanfarpour, Student Research Committee, Kerman University of Medical Sciences, Kerman, Iran.

Email: Masumeh.ghazanfarpour@yahoo.com

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1- INTRODUCTION

Menopause is a natural physiological phenomenon that most women experience between the ages of 47 and 55 (1, 2). Due to the increased life expectancy, most women are expected to spend about a third of their lives after menopause. The world's postmenopausal population is projected to reach more than 1.2 billion by 2030, with an increase of 47 million per year (3). Menopause is associated with symptoms such as hot flashes, irritability, insomnia, palpitations, difficulty concentrating or memory loss, sexual problems, and depression (4). Sexual problems are common during menopause (5). According to Lumen, the prevalence of sexual dysfunction in women aged 18-59 years is about 43%. The occurrence of sexual problems significantly reduces the quality of life of postmenopausal women (6). A study in the United Kingdom found that only 2% of patients with sexual dysfunction seek medical consultation (6).

A study in Sari showed that more than 50% of women with sexual dysfunction did not seek medical consultation (7). One of the barriers to sexual counseling is the concept of modesty present in Iranian culture. There is embarrassment towards raising sexual issues among Iranians (8). Although sexual health assessment is necessary for health care providers and sexual rights are a human right (6), only 2% of general practitioners (GPs) pay attention to their patients' sexual problems (9). Another study in the UK cited barriers such as fear of insufficient or limited personal knowledge and skills regarding sexual assessment, and fear of being seduced by patients during a discussion of sexual issues (10). Bagheri et al. (2014) investigated the barriers to holding sexual conversations before nurses in CCU wards in selected hospitals in Yazd, Iran. They reported the following barriers: overtime processes, lack of motivation, time shortage, different language of patient and nurse, patient distrust of nurse, gender difference, high density of tasks, lack of monitoring system, lack of attention and support from managers, shyness of patients, the age difference between patient and nurse, and concerns regarding confidentiality of information (11). The private nature of sexual issues has changed over time; most health care providers no longer believe that sexual issues are private (12). Weeks et al. (2002) pointed to the underestimation of sexual dysfunction and misconceptions about the medical team. One study found that contrary to the presumption of medical staff, patients are not reluctant to reply to questions about sexual issues and do not think such questions invade their privacy. Almost all patients (90%) stated that they would like the medical staff to take a sexual history from them or provide them with medical advice in this regard. Even 76% of patients who were shy of sexual conversation were willing to be asked about their sexual issues by their doctors (13).

In a study in the United States, Harsh et al. (2008) noted the effect of subjective norms on the sexual conversation of medical staff. Fear of negative reactions from other staff, lack of support from superiors and lack of role model make some medical staff reluctant to have sexual conversations (14). Given the importance of the role of midwives in sex education, there are currently many barriers to providing sex education that need to be investigated. Some international studies have suggested the role of subjective norms in midwives' sexual conversation. There have been limited studies in Iran on identifying norms for improving the quality of sex education programs. The aim of the present study is to explain the perceptions and experiences of midwives and general practitioners of subjective norms (important influential others) of sexual conversation with postmenopausal women.

2- MATERIALS AND METHODS

2-1. Methods

The present study is a qualitative descriptive study with a content analysis approach. The aim of this study is to explain the midwives' and general practitioners' perceptions and experiences of sexual conversation with postmenopausal women based on the theory of planned behavior; designing and determining psychometric properties and testing the predictive behavioral assessment questionnaire, explaining the understanding and experiences of midwives and general practitioners of barriers of sexual conversation with postmenopausal women.

Samples were selected by purposive sampling. Participants of the study included 14 midwives and 13 general practitioners working in the public and private sectors. The midwives aged 25-60 years and the physicians aged 32- 70 years. Both groups of midwives and general practitioners had three to and 44 years of work experience. Inclusion criteria included the willingness to participate in the study, being Iranian, and having at least two years of experience in a clinic or private office. The interview began with a general question such as "can you tell us about your experience of important factors influencing sexual conversation?" and continued with semi-structured questions.

The participants were asked exploratory questions to provide further explanation to clarify the subject matter. At the end of the interviews, participants were asked to write down any additional experiences or material that came to mind later and submit it to the researcher. Data saturation was obtained when no new data was reported in the interviews. Each interview with midwives and general practitioners lasted 40 to 90 minutes. The recorded interviews were transcribed verbatim immediately after the interview and were initially analyzed and coded.

To determine the strategy of qualitative data analysis, the researcher, after reviewing several relevant articles on the method of qualitative content analysis by famous people, including Granheim & Landman (2004), Hsieh & Shannon (2005), Satu Elo & Helvi Kynga (2007), and Mayring (2000) used a combination of Granheim & Landman and Hsieh & Shannon methods (15, 16). In this study, the researcher employed a deductive approach by placing codes in predetermined themes (attitudes toward sexual conversations, perceived behavioral control of sexual conversations, subjective norms toward sexual conversations, intention to have sexual conversations, and sexual conversations). The researcher also employed an inductive approach by forming sub-categories and categories in predetermined themes. In qualitative research, reliability is measured using four criteria: credibility, dependability, confirmability, and transferability (16).

2-2. Ethical consideration

This article is part of the dissertation of the Ph.D. course in Midwifery and Reproductive Health. The proposal of the present study was approved by the Ethics Committee of the Research Council of Mashhad University of Medical Sciences (ID-code: 930568). First, the researchers introduced themselves and stated the purpose of the research to the participant, and asked them for permission to conduct an interview and record their voice. The participants were assured of the confidentiality of their data. Participants then signed a written informed consent form.

3- RESULTS

A combination of Graneheim & Lundman and Hsieh & Shannon methods was used to analyze the data. At first, 183 initial codes were extracted from the 27 interviews with midwives and general practitioners. The similar codes were then

merged and finally, 25 codes were emerged in three categories and eight subcategories. Subjective norms reflect the experiences, perceptions, and beliefs of midwives and GPs about the expectations of important others from sexual conversations. Moreover, the motivation to follow reflects the motivations of midwives and physicians to meet the expectations of important others (17, 18).

Data related to subjective norms were categorized in three main categories: "expectation of understanding religious and cultural sensitivities (by family and society)", "expectation of providing services based on respect for privacy and the principle of confidentiality", and "expectation of scientific and professional performance" (**Table-1**).

Table-1: The categories and subcategories of the abstract norm theme of sexual conversation.

Code	Subcategories	Categories	Theme
The reaction of clients and their families to less sensitive sexual issues such as touching the skin etc.; the objection of the family members of medical staff to their involvement in sexual matters, refusing to continue sexual conversations by recurring negative emotional and behavioral reactions of clients.	Expecting the observance of norms and taboos (patient, patient's family and spouse, reference, and treatment staff)	Expecting to observe religious and cultural sensitivities (from family and community).	Abstract norm towards sexual conversation
The university security and the judiciary expecting to follow the plan of compliance with Sharia, fear of having sexual conversations reported to the university security by colleagues, the guidance organization expecting to preserve Islamic decency in writings and sayings, concern that the municipality and local police do not permit to hold public speeches.	Expecting to observe Islamic values in the profession		
Expecting to observe the Sharia rules of examining and touching a patient of the opposite sex, expecting to observe the Sharia rules regarding looking and touching a woman's genital parts, not examining due to respect for patients' religious beliefs, the open-mindedness of religious figures in dealing with sexual issues and their emphasis on the importance of having sexual conversations for spouse obedience.	Expecting the observance of Sharia rules/Islamic codes of conduct in the profession		
Reluctance to have a third party present during the visit, reluctance to explore privacy.	Expecting the confidentiality of private information from the treatment staff	Expecting to provide services based on respect for privacy and the principle of confidentiality	
Patients concerns about disclosure of sensitive and insensitive sexual issues, patients' expectation of confidentiality.	Expecting the patient to maintain privacy		
Expecting to be confronted openly and actively listened to, and worrying about being ridiculed by the treatment staff and relatives.	Expecting respect and consideration		
Expectations of the Health System about caring about and referring clients in the Middle-aged Health Plan, the expectation of the deputy of Health and Medical System not to receive additional tariff, expecting no specialized sexual counseling from superiors and co-workers.	Expecting the fulfillment of described assigned tasks	Expecting scientific and professional performance	
The emphasis of books and scientific references on obtaining the sexual history of patients, the emphasis of prominent psychologists on the importance of sexual issues, localization of Western medical books in accordance with the principles of Islamic laws.	Expecting to model from scientific sources and its localization		

3-1. The category of "Expectation to understand religious and cultural sensitivities (from family and society)"

Most of the study participants mentioned the need for sexual conversation with postmenopausal women while considering their specific religious and cultural sensitivities. They believed that they were expected to have sexual conversations in accordance with the norms and taboos and to adhere to the Sharia rules and Islamic principles in their profession.

The participants' experience in this field included three subcategories: "expecting the observance of norms and taboos", "expecting the adherence to Islamic principles in the profession", and "emphasis of Sharia law on preserving Islamic principles and obedience to the spouse".

3-2. The category of "Expectation to provide services based on respect for privacy and the principle of confidentiality"

Most participants believed that patients expected them to respect their privacy and keep their private information. The category of "expectation to provide services based on respect for privacy and the principle of confidentiality" includes three subcategories: "expectation of confidentiality", "expectation of to respect privacy", and "expectation of respect and consideration".

3-3. The category of "Expectation of scientific and professional performance".

The expectation of acting in accordance with professional rules and regulations and modeling from scientific sources emerged from the data of the qualitative part of the present study. A number of participants stated that the authors of scientific books and prominent scientific figures emphasize the need for holding sexual conversations.

The category of "expecting scientific and professional performance" consists of two subcategories: "expectation of fulfilling the assigned job", and "modeling of scientific resources and its localization".

4- DISCUSSION

Subjective norms refer to the social pressure on a person to behave in a specific way. Analysis of participants' experiences and perceptions in the qualitative phase led to the emergence of three categories regarding the expectations of important others. These expectations included "expectation of understanding religious and cultural sensitivities", "expectation to provide services based on respect for privacy and the principle of confidentiality", and "expectation of compliance with professional rules and regulations and compliance with scientific sources". The sub-category of "emphasis on Sharia rules and the adherence to Islamic principles" emerged from the findings of the qualitative part of the present study. Participants declined to examine the sexual parts of a patient of the opposite sex because of their belief in Sharia rules in this regard. Rashidian et al. (2013) conducted a study titled "Barriers to Sexual Care of Patients in American-Iranian Physicians in California." The majority of participants in this study were men (57%), and most of the general practitioners were Muslim (55%).

A total of 54% of the participating physicians had completed their general medicine course in Iran. A total of 1,550 questionnaires were sent to American-Iranian physicians living in California, and the response rate was 23%. Participants believed that religion ($p = 0.001$), and culture ($p = 0.001$) did not permit them to have sexual conversations. The results of the study showed that the place of birth and the place of study (Iran vs. the United States) affect their sexual conversations. Iranian physicians who had completed

their general medical education in Iran were less likely to hold sexual conversations with their patients than Iranian physicians who had completed their general medical education in the United States (19). In the study by Salehian et al., a total of 52% of cardiologists declined to have sexual conversations with cardiac patients due to their religious and cultural beliefs (20).

"Expectation of compliance with professional rules and regulations" was one of the subcategories that emerged from the qualitative part of the present study. A number of participants stated that their superiors or colleagues did not consider sexual conversations to be part of the midwives' profession and expected them to refuse to have sexual conversations due to a lack of expertise. This shows that despite the fact that sexual conversation is part of the job description of midwives, many people, even midwifery experts, are unaware of their job descriptions. Kautz et al. (1990) conducted a study in the United Kingdom to investigate the reasons for nurses' non-compliance with sexual care standards in five areas: gynecology, psychiatry, surgery, pediatrics, and the ICU. This study was performed on 312 treatment staff. Most of the participants believed that their superiors did not approve of sexual conversation (21), but the reason for this disapproval was not mentioned in this quantitative study.

Some participants in the public sector also stated that their colleagues did not welcome sexual conversation due to a large number of clients and time constraints. The findings of the present study on the role of colleagues in conducting sexual conversation are consistent with the findings of Kautz et al. (21), but are inconsistent with the findings of a study by Salinas et al. (22). Most participants in the study by Salinas et al. believed that their colleagues supported them even if there was a time constraint at work, but the reasons for this support are not discussed. Adherence to Sharia rules led some participants in the quality section to refuse to have sexual conversations. In this regard, some religious participants refused to study sex and watch sexual films and participate in sex workshops due to fear of committing a sin. McKelvey et al. (1999) conducted a study on the sexual knowledge and attitudes of Australian medical and nursing students. The study population included first-to-fifth-year medical students and first-to-third-year nursing students. The response rate to the questionnaire was 90%. Data analysis showed a significant relationship between demographic variables and students' attitudes and sexual knowledge. In this study, the medical staff who were present in religious and charity services had lower sexual knowledge compared to other groups (23).

According to the participants, the patients expected them to observe Sharia rules and Islamic principles. For example, they expected the observance of Sharia laws and to be examined and touched by the medical staff of the same sex. In this regard, some previous studies have addressed patients' preferences for conversation and examination by the staff of the same and opposite sex. In the study by Dogan et al. (24) in Turkey, the majority of nurses (77%) did not follow specific preferences for a sexual conversation with male and female patients, and only 22% of nurses preferred to talk to patients of the same sex.

In a qualitative study in the United Kingdom by Gott et al. (2004) (7), GPs and nurses preferred to have sexual counseling with patients of the same sex. Their reasons for choosing the same sex were feeling more comfortable in having sexual counseling with patients of the same sex and believing that patients were more likely to have sexual conversations with the staff of the same sex.

Additionally, participants in the present study refused to have sexual conversations with a patient of the opposite sex because of their own or their patients' religious beliefs. The present study, beyond all other studies, showed that the participants believe that the Islamic organizations, university security officers, judicial authorities, and public offices expect them to observe Islamic principles at work. Clients also expect them to provide services based on respect for privacy and the principle of confidentiality.

5- CONCLUSION

Sexual conversation of midwives and general practitioners is influenced by various legal or natural persons in the society, such as menopausal clients, patients' spouses, professional rules and regulations, university security officers, colleagues, their families, and judicial authorities. Some participants considered sexual conversation as part of their Islamic religious duties and provided such counseling to their patients. However, many other medical staff declined to examine, touch, and look at the genitals of the same- and opposite-sex (female) clients due to Sharia rules.

6- AUTHORS' CONTRIBUTIONS

Study conception or design: TK, RL, and MG; Data analyzing and draft manuscript preparation: MG; Critical revision of the paper: TK; Supervision of the research: TK and RL; Final approval of the version to be published: TK, RL, and MG.

7- CONFLICT OF INTEREST: None.

8- REFERENCES

1. Akbarzadeh M, Ghaem Maghami M, Yazdan Panahi Z, Zare N, Azizi A, Mohagheghzade AJEBC. Comparative effects of dry cupping therapy and acupressure at acupoint (BL23) on postpartum anxiety in nulliparous women. 2013;3(2):37-48.

2. Xu J, Bartoces M, Neale AV, Dailey RK, Northrup J, Schwartz KLJTJotABoFP. Natural history of menopause symptoms in primary care patients: a MetroNet study. 2005;18(5):374-82.

3. Bahri N, Latifnejad Roudsari R, Azimi Hashemi M. Menopause research studies through passage of time: Shifting from biomedical to holistic approaches. The Iranian Journal of Obstetrics, Gynecology and Infertility. 2015;18(154):19-34.

4. Rajaeefard A, Mohammad-Beigi A, Mohammad-Salehi N. Estimation of natural age of menopause in Iranian women: A meta-analysis study. Koomesh. 2011;13(1):1-7.

5. Aliei MM, Ghelichkhani F, Pakghohar M, Abadi MMMJP. Effectiveness of a sex education program on sexual function in postmenopausal women with sexual dysfunction: A randomized trial. 2016;15(2):181-92.

6. Arman S, Hasan Zahraee R. A comparative Study on women's sexual functioning disorders before and after menopause. Journal of Arak University of Medical Sciences. 2006;8(3):1-7.

7. Gott M, Galena E, Hinchliff S, Elford HJFp. "Opening a can of worms": GP and practice nurse barriers to talking about sexual health in primary care. 2004;21(5):528-36.

8. Refaei Shirpak K, Chinichian M, Eftekhar Ardebili H, Pooreza A, Ramezankhani A. The sexual health education needs of women attending family planning health centers in Tehran. Payesh; 2010.

9. Read S, King M, Watson JJJoPH. Sexual dysfunction in primary medical care: prevalence, characteristics and detection by the general practitioner. 1997;19(4):387-91.

10. Ozgoli G, Sheikhan Z, Dolatian M, Valaee N. The survey of obstacle and essentiality health providers for sexual health evaluation in women referring to health centers related of Shahid Beheshti University of Medical Sciences. Pajoohandeh Journal. 2014;19(4):175-83.

11. Bagheri I , Jafary Manesh H , Matory P, Ranjbaran M , Dadgari A , pakcheshm B. Survey of nurse's perspective about barriers to

education of sexual activity in patients with myocardial infraction. Education and Ethics in Nursing. 2015;4(1):33-42.

12. Gott M, Galena E, Hinchliff S, Elford H. "Opening a can of worms": GP and practice nurse barriers to talking about sexual health in primary care. Family practice. 2004;21(5):528.

13. Weeks DJJS, Therapy R. Sex for the mature adult: Health, self-esteem and countering ageist stereotypes. 2002;17(3):231.

14. Harsh V, McGarvey EL, Clayton AH. Physician attitudes regarding hypoactive sexual desire disorder in a primary care clinic: A pilot study. The journal of sexual medicine. 2008;5(3):640-5.

15. Hsieh H-F, Shannon SE. Three approaches to qualitative content analysis. Qualitative health research. 2005;15(9):1277.

16. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse education today. 2004;24(2):105-12.

17. Ajzen I. The theory of planned behavior. Organizational behavior and human decision processes. 1991;50(2):179-211.

18. Ajzen I. Constructing a TPB questionnaire: Conceptual and methodological considerations. 2002.

19. Rashidian M, Minichiello V, Knutsen SF, Ghamsary M. Barriers to sexual health care: a survey of Iranian-American physicians in California, USA. BMC health services research. 2016;16(1):1-11.

20. Salehian R, Naserbakht M, Mazaheri A, Karvandi MJIJoP, Sciences B. Perceived barriers to addressing sexual issues among cardiovascular patients. 2017;11(2).

21. Kautz DD, Dickey CA, Stevens MNJJoNQA. Using research to identify why nurses do not meet established sexuality nursing care standards. 1990;4(3):69-78.

22. Salinas GD, Abdolrasulnia M, Parish S, Sadovsky R. A model of physician intentions toward initiating a dialogue about sexual health with women. International Journal of Person Centered Medicine. 2011;1(2):317-28.

23. McKelvey RS, Webb JA, Baldassar LV, Robinson SM, Riley GJA, Psychiatry NZJo. Sex knowledge and sexual attitudes among medical and nursing students. 1999;33(2):260-6.

24. Dogan S, Demir B, Eker E, Karim S. Knowledge and attitudes of doctors toward the sexuality of older people in Turkey. International Psychogeriatrics. 2008;20(5):1019-27.